STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G193	A. BUILDING _____ B. WING _____	R 03/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW 02	74 'W' ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This monitoring visit was conducted on March 18, 2009. A random sample of three clients was selected from a resident population of three men and three women with various disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.	{W 000}	APR - 2 2009 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for six of six clients in the facility. (Client #1, Client #2, Client #3, Client #4, Client #5 and Client #6) The finding includes: Cross Refer to W441. The QMRP failed to ensure that staff had received effective training on documenting evacuation drills under varied conditions.	{W 159}	On March 27, 2009, the staff were retrained on documenting evacuation drills, using each means of egress, and the quarterly schedule for conducting evacuation drills. (see Attachment #1) In the future, the Residential Manager will ensure that the documentation for evacuation drills is completed properly and various means are used by each shift, as well as evacuation drills conducted on each shift on a quarterly basis.	3/27/09
{W 189}	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	{W 189}	The current form used did not list all five means of egress, therefore, a new form was developed. (see Attachment #2) Monitoring will be conducted by the Quality Assurance Coordinator.	3/27/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad West MD | TITLE: Administrator | (X6) DATE: 3/30/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 189}	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently for six out of six clients in the facility. (Client #1, Client #2, Client #3, Client #4, Client #5 and Client #6) The finding includes: Cross Refer to W441. The facility failed to ensure that staff had received effective training on documenting evacuation drills under varied conditions.	{W 189}	On March 27, 2009, the staff were retrained on documenting evacuation drills, using each means of egress, and the quarterly schedule for conducting evacuation drills. (see Attachment #1) In the future, the Residential Manager will ensure that the documentation for evacuation drills is completed properly and various means are used by each shift, as well as evacuation drills conducted on each shift on a quarterly basis.	3/27/09
{W 441}	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions for six of six clients in the facility. (Client #1, Client #2, Client #3, Client #4, Client #5 and Client #6) The finding includes: Review of the fire drill log book on March 18, 2009, at approximately 11:45 AM revealed two basement exits and the exit leading from Client #1's bedroom had not been used during stimulated fire drills. In an interview with the Qualified Mental Retardation Professional	{W 441}	On March 27, 2009, the staff were retrained on documenting evacuation drills, using each means of egress, and the quarterly schedule for conducting evacuation drills. (see Attachment #1) In the future, the Residential Manager will ensure that the documentation for evacuation drills is completed properly and various means are used by each shift, as well as evacuation drills conducted on each shift on a quarterly basis.	3/27/09

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{W 441}	Continued From page 2 (QMRP)on March 18, 2009 at approximately 11:50 AM it was acknowledged the two basement exits and the exit leading from Client #1's bedroom had not been used during stimulated fire drills. There was no evidence on file at the time of survey to subetantiate that all exits were used during the evacuation drills.	{W 441}		

Health Regulation Administration

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	HFD03-0202	A. BUILDING _____ B. WING _____	R 03/18/2009

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{R 000}	INITIAL COMMENTS This monitoring visit was conducted on March 18, 2009. A random sample of three residents was selected from a resident population of three men and three women with various disabilities. The findings of the survey were based on observations, interviews with residents and staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.	{R 000}		
{R 125}	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check for two of six staff in the facility. (Staff #2 and Staff #6). The finding includes: Review of the personnel records on March 18, 2009 at approximately 1:00 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for two direct care staff. In an interview with the Qualified Mental Retardation Professional (QMRP) on	{R 125}	A criminal background check had been conducted for Staff #2 on 03/09/09, but was inadvertently not given to the surveyor at the time of the monitoring visit. (See Attachment #3). A criminal background check will be requested and obtained for Staff #6 by April 6.	3/09/09 4/06/09

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{R 125}	Continued From page 1 March 18, 2009 at approximately 1:15 PM it was acknowledged Staff #2 and Staff #6 did not have criminal background checks for the previous seven (7) years, in all jurisdictions where they have worked or resided. There was no documented evidence all staff had criminal background checks for the previous seven (7) years, in all jurisdictions where they have worked or resided.	{R 125}		

Health Regulation Administration

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(I 000)	INITIAL COMMENTS This monitoring visit was conducted on March 18, 2009. A random sample of three residents was selected from a resident population of three men and three women with various disabilities. The findings of the survey were based on observations, interviews with residents and staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.	(I 000)		
(I 090)	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the GHMRP was maintained in a safe manner. The finding includes: Observation on March 18, 2009, at approximately 12:30 PM, revealed the back storm door was missing a door handle and the door could not be closed securely. In an interview with the Qualified Mental Retardation Professional (QMRP) on March 18, 2009, at approximately 12:35 PM it was acknowledged the back storm door was missing a door handle and the door could not be closed securely. There was no evidence the back storm door was maintained in a safe manner.	(I 090)	The handle for the back storm door was replaced and the door can now close securely. In the future, the Residential Manager will conduct weekly house rounds to check for any maintenance concerns and will in turn report them to the Environmental Manager for repair, this process will be monitored by the Quality Assurance Coordinator.	3/22/09
(I 206)	3509.6 PERSONNEL POLICIES	(I 206)		

Fred R West J. MD — Administrator — 3/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Health Regulation Administration

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{I 206}	Continued From page 1 Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings for seven of fourteen direct care staff. (Staff #1, Staff #2, Staff #3, Staff #4, Staff #5, Staff #6 and Staff #7) The finding includes: Review of personnel records on March 18, 2009, at approximately 12:45 PM, revealed the GHMRP failed to provide evidence of physical examinations for seven direct care staff. In an interview with the Qualified Mental Retardation Professional (QMRP)on March 18, 2009, at approximately 12:50 PM it was acknowledged Staff #1, Staff #2, Staff #3, Staff #4, Staff #5, Staff #6 and Staff #7 did not have annual health screenings on file. There was no documented evidence all staff had annual health screenings on file.	{I 206}	Each staff person listed in the Statement of Deficiencies Report was given a letter to indicate that his/her health certificate is due. (see Attachment #4. If the certificate is not received by April 18, 2009, he she will be removed from the schedule. In the future, the Residential Manager will ensure that all health certificates for the staff are updated and maintained in his/her personnel record for review by monitoring agencies. This process will be monitored by the Quality Assurance Coordinator.	3/27/09